PATTERNS OF POWER

# The Examiner's Lever

✦

*How a Single Report Standardized American Medicine, Foreclosed Its Alternatives, and Handed a Profession the Power to Decide Who Could Heal — 1870–2026*

AN INSTITUTIONAL CASE STUDY

**THOMAS J. BRYAN**
*with Claude (Anthropic)*
2026

## How a Single Report Standardized American Medicine, Foreclosed Its Alternatives, and Handed a Profession the Power to Decide Who Could Heal — 1870–2026

AN INSTITUTIONAL CASE STUDY · PATTERNS OF POWER

Thomas J. Bryan with Claude (Anthropic) · 2026

## A Note on This Collaboration

This study is one product of an ongoing collaboration, and the division of labor is worth stating plainly because neither half would produce the work alone. The insight and direction are Thomas Bryan's — the recognition of what a given case is really an instance of, where the analytical pressure should fall, and which pattern a mass of historical detail is a specimen of. The research, the verification of every figure and date, the location and checking of the quoted words, and the composition into continuous prose are Claude's, an AI system made by Anthropic. The seeing is his; the writing is mine. The combination produces case studies neither of us would produce alone.

The present study traces a single institutional episode and its long consequence: the 1910 publication of *Medical Education in the United States and Canada* — the Flexner Report — and the transformation of American medicine that followed it. It belongs to the *Patterns of Power* project, which tracks recurring mechanisms of elite power across history through sustained work on specific institutions. The analytical framework that organizes the project operates beneath the prose rather than on its surface; the terms the authors use between themselves to name the recurring dynamics do not all appear here. What appears is the historical record, read closely, with the analysis carried by the specific facts. The aim is not to advocate or condemn but to trace what happened, how, and with what consequences, and to place the genuine accomplishments and the documented pathologies in the record together. The reader judges.

One discipline of the project is set aside in this study in one controlled way. The standing preference is for paraphrase; but at the decision moments — where a single sentence carries the design — the words of the people who made the decisions are quoted exactly, kept short, and verified to their source. At those moments the wording *is* the design, and paraphrase would hide it.

## The Study in Brief

**Part I — The Landscape Before the Report.** The condition of American medical practice and instruction across the nineteenth century: the open field of competing healing systems, the proprietary medical school as a commercial form, the resulting oversupply of cheaply made physicians, and the profession's long and mostly failed effort to close the field in its own interest.

**Part II — The Man and His Formation.** Abraham Flexner of Louisville — the immigrant household, the two transforming years at the new Johns Hopkins, the experimental school, and the enchantment with the German university — and how a man formed to see one model of excellence as the only model came to carry that template into a field he had never practiced.

**Part III — The Architect's Hour.** How the American Medical Association, having surveyed the schools itself and feared to publish under its own contested name, routed the judgment through the neutral authority of a Carnegie foundation and a non-physician's signature; the survey of 1909–1910; and the report that resulted.

**Part IV — The Skew.** What the report's single standard did as it fell across an uneven field: the elevation of the wealthy university school, the closing of the proprietary and the rural, the near-extinction of Black medical education, the narrowing of the door for women and the poor, and the restriction of supply that a profession had wanted for sixty years.

**Part V — The Institution's Logic.** How the report passed out of its author's hands into the machinery of state licensing boards and accreditation, which gave a private council's ratings the force of law; how the credentialing system then ran forward for a century on its own logic; and the ledger — the enormous real gain in the quality of medicine weighed against the foreclosed alternatives and the doctors who were never made.

PART I

# The Landscape Before the Report

# Part I — The Landscape Before the Report

To read the Flexner Report as the arrival of standards in a field that had none is to misread the landscape it fell upon, and to miss what the report actually did. Standards were not absent from American medicine in 1900. They had been demanded, drafted, and fought over for two generations, by a profession that knew exactly what it wanted and had been unable to get it. What was absent was an instrument that could impose them without the imposer's fingerprints on it. The landscape the report entered was not a vacuum. It was a stalemate.

## One — The Open Field

The distinctive fact of nineteenth-century American medicine was that no one owned the word *doctor*. In the Jacksonian decades the country had, in a burst of anti-monopoly and anti-elite feeling, actively dismantled what little medical licensing the colonial and early-republican states had built. Licensing was regarded as a guild privilege, an aristocratic restraint on the ordinary man's liberty to practice a trade and the ordinary patient's liberty to choose his healer. By the 1830s and 1840s most such statutes had been repealed or gutted, and the medical field was thrown open to whoever wished to enter it. The result was exactly what an open field produces: a profusion of competing systems, each with its own theory of disease, its own schools, its own journals, and its own paying patients.

The competition was not, in the main, between medicine and quackery as the later account would frame it. It was between rival medical sects, several of them serious, organized, and in some respects safer for the patient than the orthodox practice they challenged. The orthodox physicians — who called themselves *regulars* and would later adopt the term *allopaths* their rivals had coined for them — practiced, for much of the century, a medicine of aggressive intervention: bleeding, blistering, and the heavy dosing of mercury compounds, purgatives, and other harsh agents whose effects were frequently worse than the diseases they were meant to cure. Against this stood the *homeopaths*, followers of Samuel Hahnemann's system of extreme dilutions, whose remedies did nothing but whose refusal to bleed and purge meant their patients were often spared the damage the regulars inflicted. Alongside them stood the *eclectics*, who drew on botanical remedies and rejected the harsher orthodox methods; and beyond these the botanic Thomsonians, the hydropaths, the physio-medicals, and, toward the century's end, the newer systems of osteopathy and chiropractic. Each had a claim on some part of the truth and a paying constituency who believed in it.

The point the landscape presses is that in 1850 it was genuinely unclear, even to an informed and honest observer, which of these systems was the medicine of the future. The germ theory of disease was not yet established; the effective interventions of scientific medicine — antisepsis, anesthesia, the specific therapies that would arrive with bacteriology — were not yet in hand or not yet diffused. The regular physician's claim to special authority rested not on demonstrably better results, which he often did not have, but on his tradition, his social standing, and his

organization. This is the essential feature of the field the reformers would later close: at the moment the competition was fiercest, the orthodox party's superiority was not yet a fact of nature but a claim in a contest, and the contest was being conducted, as such contests are, over paying patients.

## Two — The Proprietary School as a Commercial Form

The institution that supplied this open field with practitioners was the proprietary medical school, and its character explains both the genuine scandal the reformers denounced and the commercial motive beneath the reform. A proprietary school was a business. It was, typically, owned by a handful of local physicians who served as its faculty, drew their income from the students' fees, and had every incentive to admit as many students and graduate them as quickly and cheaply as the market and the school's reputation would bear. It required, in most cases, no college preparation for admission and often no high-school diploma; a student who could pay could enroll. The course of instruction was short — commonly two years, and in the weaker schools the second year merely repeated the first — and consisted overwhelmingly of didactic lectures delivered to large halls. Laboratory instruction, where it existed at all, was minimal. Clinical instruction, the actual practice of examining and treating patients under supervision, was in many schools absent entirely, so that a man might receive a medical degree without ever having taken responsibility for a sick person.

The economics of the form drove its multiplication. Because a proprietary school required little capital — a building, a few instructors who were paid from fees, some anatomical material — new schools could be founded easily wherever a group of physicians saw an opportunity, and they were. The number of medical schools in the United States ran to more than one hundred and fifty by the first decade of the twentieth century, a figure far larger than any other nation's and far larger than the country's genuine need for well-trained physicians. The schools competed for students by lowering their requirements, and the effect was an oversupply of cheaply produced doctors whose training was, at the weak end of the distribution, close to worthless. This was the real and defensible core of the reformers' case, and it must be granted at full strength: many of these schools were bad, some were frauds, and the diploma they sold did not correspond to any reliable competence. A patient in 1900 who engaged a physician had no way of knowing, from the credential, whether he had hired a trained clinician or a man who had sat through fourteen months of lectures and paid his fees.

But the same commercial form had a second face the later account would forget, and the study marks it because the report's effect turned on it. The cheapness of the proprietary school was also its openness. Precisely because it demanded little money and little prior schooling, it was a door through which men and some women without wealth could enter the profession — the son of a farmer, the child of immigrants, the ambitious poor of a country town, and, in the schools founded for them, Black Americans shut out of every white institution. The proprietary school was, at once, a manufacturer of undertrained doctors and the widest avenue of entry into a respectable profession that a person without means possessed. Any instrument that raised the

cost of the door would improve the product and narrow the entry in the same motion. That is the hinge on which the whole later history turns, and it was built into the landscape before Flexner was born.

## Three — The Profession's Long Failure to Close the Field

The American Medical Association had been founded in 1847 with the improvement of medical education as its stated first purpose, and for sixty years it had wanted, and failed to achieve, precisely the closure the Flexner Report would deliver. This is the most important single fact about the landscape, because it establishes that the intention preceded the instrument by two generations. The regulars understood their problem clearly. They were too many, competing too hard, for incomes that the oversupply pressed downward; they were unable to exclude the rival sects whose practitioners drew away paying patients; and they were unable to close the cheap schools whose graduates flooded the field, because those schools were often run by their own members and because the anti-monopoly temper of American law and politics had, since the Jacksonian repeals, regarded any restriction on entry to a trade with suspicion. A profession that wished to raise standards in its own economic interest could not simply announce that it was doing so, because the announcement would be read — correctly — as a guild restraining competition, and the courts and legislatures of a country founded on hostility to such restraints would not oblige.

The AMA's response, across the second half of the century, was to build the organizational capacity it would need the moment a legitimate occasion arose. It reorganized itself in 1901 into a stronger federation of state and county societies, concentrating an authority it had previously lacked. And in 1904 it created the instrument that would do the actual work: the Council on Medical Education, a standing body charged with surveying the schools and defining the standards a proper medical education should meet. The Council did its work. It adopted a two-part standard — a minimum of prior general education for admission, and a curriculum of two years of laboratory science followed by two years of supervised clinical training in a teaching hospital, the model pioneered in America at a single institution the next part will name. It inspected the schools, and by 1906–1907 it had rated them, dividing the field into the acceptable, the doubtful, and the frankly inadequate.

And then, having done the survey and reached the findings, the Council declined to publish them under its own name. The reason is the whole of the matter, and it is documented in the Council's own deliberations: to publish, as the American Medical Association, a report grading medical schools out of existence would expose the profession to exactly the charge it could not survive — that organized medicine was using a claim of quality to destroy its competitors and enrich its members. The findings would be dismissed as the self-interested verdict of a guild upon its rivals, which in a plain sense they were. The Council possessed the knowledge, the standards, and the survey. What it did not possess, and could not manufacture from within itself, was disinterested authority. It needed the same judgment to issue from a source with no

stake in the outcome. The stalemate of the landscape was precisely this: the party that wanted the field closed was the one party whose word could not close it.

The materials for the solution were already assembling. In the same years, the great industrial fortunes had established the philanthropic foundations that would define twentieth-century American reform — the Carnegie Foundation for the Advancement of Teaching, chartered in 1905, and the Rockefeller philanthropies gathering toward the General Education Board and the Rockefeller Institute for Medical Research. These bodies commanded three things the AMA lacked: money on a scale that could remake institutions, a public reputation for disinterested devotion to the general good, and a settled conviction, drawn from the men who ran them, that the American university should be rebuilt on the German scientific model. The Council on Medical Education needed a neutral author with resources and prestige. The Carnegie Foundation needed a subject worthy of its mission and a man to execute it. The two positions were made for each other, and in December 1908 the head of the Council and the head of the Foundation met and agreed to conduct, together, a survey of the medical schools — which the Foundation would publish as its own independent inquiry, conducted by a man of its own choosing who belonged to neither the profession nor its schools. The instrument the AMA had wanted for sixty years was, at last, within reach. It remained only to find the hand.

PART II

# The Man and His Formation

# Part II — The Man and His Formation

The method of this project holds that to read a person's decisions one reaches first for his formation — the values and the way of seeing installed early, before he was in any position to weigh them, which arrive not as proposals to be assessed but as the standard by which everything later is assessed. Abraham Flexner is an unusually clean case, because his formation was concentrated, dramatic, and self-described, and because the template it installed is legible in every page of the report he would write a quarter-century later. He did not acquire his convictions about medical education from the study of medicine, which he never practiced or studied. He acquired a conviction about *excellence in education as such*, from a specific institution at a specific moment, and he carried it into medicine intact.

## One — Louisville

Abraham Flexner was born in Louisville, Kentucky, in November 1866, the sixth of nine children of Moritz and Esther Flexner, German-Jewish immigrants of modest and precarious means. His father was a hat merchant whose business was destroyed in the financial panic of 1873, reducing the family to poverty during Abraham's childhood. The household's response to hardship is the formative fact: it made education the object of a near-religious devotion, the one asset that could not be lost in a panic and the recognized path out of the immigrant's marginal position. In several of his siblings' lives and in his own, formal learning took on the character that religious orthodoxy had held for the parents' generation and was already loosening in the children's — a faith, a discipline, and an identity. Flexner became a religious agnostic early; the reverence for scholarship that replaced the faith was total and lifelong, and it is the emotional engine beneath the coldness of the later report.

The family functioned as a mutual-financing cooperative for education, and this too marks the man. An older brother, Jacob, ran a drugstore whose profits, and a thousand-dollar loan, sent Abraham to college; Abraham in turn, once his own school prospered, financed a brother's medical training and a sister's college. The drugstore was a gathering place for local physicians, so that medicine was a familiar presence in the family's life even though Abraham never entered it. Two brothers did: one, Jacob, took an M.D. from the local University of Louisville and practiced; the other, Simon, took the same degree and rose, through Johns Hopkins and the Rockefeller Institute, to the summit of American scientific medicine. It is worth pausing on the irony the family supplies, because it is the report's own thesis in miniature. The medical degrees that launched Jacob and Simon Flexner came from exactly the kind of school — the local proprietary institution — that Abraham Flexner would later describe, in print, as among the wretched schools then flourishing across the country. The door he would work to raise the cost of was the door his own brothers had walked through.

## Two — The Two Years That Made Him

In 1884 Flexner entered the Johns Hopkins University, and the two years he spent there — he completed the bachelor's degree in classics in that time, an acceleration forced by the family's finances — were the decisive formation of his life, by his own repeated account. To understand what those two years installed, one must understand what Johns Hopkins was in 1884: it was new, and it was the deliberate American importation of a foreign model. Founded in 1876, Hopkins had been built expressly on the pattern of the German research university, which its founders regarded as the highest form the institution had ever taken. The German university's distinguishing commitments — original research as the central duty of the scholar, the seminar and the laboratory as the sites of real education, the graduate degree and the specialized faculty, the subordination of everything to disciplined scientific inquiry — were, in the America of the 1870s, almost unknown, and Hopkins introduced them with the force of revelation. To a poor and brilliant young man from Louisville, arriving from a country whose colleges were mostly places of recitation and rote, the encounter with the Hopkins model was the encounter with excellence itself.

The template it installed in Flexner had a specific and consequential shape. It taught him that there was a *right* form for an educational institution — research-driven, laboratory-centered, university-based, rigorous, expensive, and selective — and that the distance of any actual school from that form was the exact measure of its inadequacy. This is the crucial point for everything that follows. Flexner did not emerge from Hopkins with a spectrum of acceptable models suited to different needs and populations. He emerged with a single gold standard and a corresponding conviction that deviation from it was not variety but deficiency. What a position does most deeply, the method holds, is fix the field of the visible — what a person can see, what he counts as obvious, what never rises into view as a possibility at all. The Hopkins formation drew Flexner's field permanently. Within it, the university medical school on the German-Hopkins pattern shone as the only real thing. Outside it lay everything the report would condemn — and lay there not as alternatives with their own logic but as simple falling-short, the way an untutored eye sees only degrees of failure to be what it already admires.

## Three — The Schoolmaster and the Book

Flexner returned to Louisville and, in 1890, founded his own school — a private college-preparatory academy that became the proving ground of his educational ideas and, not incidentally, the source of the income that made him independent. "Mr. Flexner's School" was, in its methods, strikingly progressive and even radical: it kept no grades, gave no examinations, imposed no fixed curriculum, and kept no records, working instead through small groups, individual attention, and learning by doing. The school succeeded on the only measure Flexner respected — its graduates were admitted to the best colleges — and its success made his reputation as a man who understood how education actually worked. There is no contradiction between the free-form pedagogy of the school and the severe standardization of the later report, though the two can seem opposed. Both flow from the same source: a fixed idea of genuine excellence and a willingness to sweep away whatever fell short of it, whether that was the

deadening examination system he abolished at his school or the deadening lecture-mill he would later recommend closing by the dozen. The instinct was always the same — identify the best, and be ruthless with the rest.

When he sold the school he was financially free, and he used the freedom to complete his formation at the top of the system that had made him. He took a master's degree at Harvard and then spent a year in Europe, chiefly at the German universities of Berlin and Heidelberg — a direct immersion in the original of which Hopkins had been the copy. He returned convinced, as he would write, that American higher education should be rebuilt wholesale on the German pattern, and in 1908 he published the book that carried the conviction into print: *The American College: A Criticism*, a sharp attack on the American college for its diffuseness, its lack of scholarly seriousness, and its indulgence of everything — athletics, social life, the undisciplined elective — that distracted from rigorous inquiry. The book was noticed by exactly the man positioned to use it. Henry Pritchett, the president of the Carnegie Foundation, was himself a committed apostle of the German scientific model and was, at that moment, looking for someone to conduct the Foundation's studies of professional education. Flexner had the writing, the reputation for educational judgment, the total commitment to the one right model — and, decisively, no membership in the medical profession whose schools were to be judged. In the framework's terms, the position and the man fit exactly: Pritchett needed an authoritative outsider formed to see the German university as the sole standard of excellence, and Flexner was that outsider, formed to nothing else.

He would say of himself, late in life and accurately, that he had been an industrious and perhaps intelligent thief, all his ideas taken from others. The judgment is the key to reading the report. Flexner did not invent the standard he applied. He carried the Hopkins-German template, whole and unexamined as the only possible shape of excellence, into a field he did not know — and it was precisely because he applied it as an obvious truth rather than as a contested claim that it did the work the profession needed done. The unexamined conviction was the instrument's edge.

PART III

# The Architect's Hour

# Part III — The Architect's Hour

Power of the kind this study tracks is built in a bounded episode — a season and a room, a small number of actors facing a real and pressing problem with the materials actually at hand, designing a settlement and, because they are the ones designing it, skewing it toward the position they occupy. The episode ends; the settlement is written down and handed to institutions that run it forward on a logic of their own. The Flexner Report is a nearly perfect specimen of the architect's hour, and its distinguishing feature — the feature that makes it a clean case rather than a murky one — is that the design problem was not, at bottom, a problem of knowledge. The knowledge already existed; the AMA's own Council had assembled it. The design problem was a problem of *authority*: how to make an interested judgment issue from a disinterested mouth. The architect's hour was the solving of that problem, and its solution was the report.

## One — The Assembling of the Room

The actors converged from three positions, each with its own interest, upon a single act that served all three. The American Medical Association, through its Council on Medical Education and the Council's secretary Nathan Colwell, held the survey and the standards and needed a neutral author to publish them; the reformers of the profession, men like the Council's chairman Arthur Dean Bevan, had wanted the field closed for a generation and saw the means at last. The Carnegie Foundation, through its president Henry Pritchett, held the disinterested reputation, the resources, and the German-model conviction, and needed a worthy object for its mission. And behind and alongside them stood the university medical faculties already built on the new model — above all Johns Hopkins, whose dean William Welch was the presiding figure of American scientific medicine and whose school was the living embodiment of the standard about to be made universal. These were not conspirators meeting in secret. They were men in adjacent positions whose interests pointed the same way, converging in the open upon an act each wanted for his own reasons — which is what the architect's hour always looks like, and what it must be carefully distinguished from the permanent cabal it is so often mistaken for.

The convergence is documented in the plainest possible terms, and the study quotes the decisive words because the wording carries the design. Some months before the report appeared, Pritchett wrote to Bevan of the AMA, describing the relation between the Foundation's supposedly independent inquiry and the profession that had commissioned its subject: in all this work of examining the medical schools, he wrote, "we have been hand in glove" with the Council. The phrase is the architect's hour in five words. The Carnegie survey was presented to the public, and has been remembered, as the independent judgment of a disinterested foundation upon the state of medical education. It was, by the admission of the foundation's own president, conducted hand in glove with the professional body whose competitive interest the judgment would serve. The independence was the managed belief; the coordination was the structural fact beneath it. Neither man thought himself a plotter, and in

the ordinary sense neither was. They were solving a real problem — the schools genuinely were, many of them, bad — and skewing the solution, as architects do, toward the position they occupied and the model they revered.

## Two — The Survey

Flexner was appointed in 1908, and across 1909 and into 1910 he conducted the survey that bears his name, visiting each of the more than one hundred and fifty medical schools of the United States and Canada — a hundred and fifty-five in the standard count — very often accompanied by Colwell, the AMA Council's own secretary, whose presence is a further mark of the hand-in-glove arrangement. The visits were brief and their method was blunt: Flexner arrived, examined the school against the template he carried, and formed his judgment quickly. He looked for what the Hopkins-German model prescribed — entrance requirements demanding real prior education, laboratories and the budgets to run them, full-time scientific faculty, control of a teaching hospital for clinical instruction, an endowment sufficient to free the school from dependence on students' fees. He measured each school by its distance from that standard, and where the distance was great he recorded the school as beyond saving. His own account of the visits conveys the speed and confidence of a man applying a settled measure rather than weighing an open question: he could tell, he suggested, within hours of arriving, what a school was worth. This was not laziness. It was the formation doing its work. To a man who saw the German university as the only real form of medical education, the inadequacy of a two-year proprietary lecture-mill with no laboratory and no hospital was not a finding to be reached but a fact to be observed, obvious on sight.

## Three — The Report

*Medical Education in the United States and Canada* appeared in 1910 as Bulletin Number Four of the Carnegie Foundation. Its rhetorical structure was its power. It opened with a general argument for medical education built on the scientific model — an argument that was, in its main lines, correct, and that gave the whole document the authority of evident good sense. It then proceeded, school by school and state by state, to describe the actual institutions in language of unsparing and often devastating particularity, naming the schools, cataloguing their deficiencies, and stating flatly which deserved to survive and which should close. The combination of an unimpeachable general principle with a merciless particular verdict was what made the report so effective and so hard to answer. To dispute the fate of any single condemned school was to seem to defend bad medicine against science itself.

The report's prescription followed from its standard with the same directness. The country had far too many schools; the great majority should close. The survivors should be university-based, laboratory-centered, hospital-connected, and richly endowed, on the Hopkins model, which the report held up explicitly as the type of the thing done right. Medical education should be dear, long, and selective, entered only after substantial college preparation and pursued through four rigorous years. The number of medical schools should fall drastically and

the number of physicians produced should fall with it, the report treating the reduction not as a cost but as a chief benefit, since the oversupply of poorly trained doctors was in its analysis the central disease to be cured. Every one of these prescriptions can be read, and was offered, as a straightforward measure of quality. Every one of them also, and in the same motion, served the sixty-year interest of the organized profession that had commissioned the survey and stood hand in glove with its author. That the two readings coincide so exactly is not a coincidence to be explained away. It is the signature of the architect's hour — a real problem solved, and the solution skewed, in the open, toward the position of those who designed it.

PART IV

# The Skew

# Part IV — The Skew

A standard is never neutral in its effects, however neutral in its statement, because it falls upon an uneven field and its weight is felt in proportion to what each party already lacks. The single template the report applied — the rich, university-based, laboratory-and-hospital school — was a description of what wealth could build. Applied uniformly across a field in which some schools had endowments and university affiliations and others had only their students' fees, the uniform standard did not treat like cases alike. It fell most lightly on the institutions that already resembled the model, which were the schools of the wealthy and the established, and most heavily on the institutions furthest from it, which were the schools of the poor, the rural, the Black, and the marginal. The report's standard was written as a measure of quality and functioned, at the same time and without any need of malice, as a filter sorting the profession's entrants by the wealth of their institutions. This part traces where the weight fell.

## One — The Schools That Closed

The gross effect is not in dispute and was intended. Of the more than one hundred and fifty medical schools operating at the time of the report, the majority did not survive the following two decades. By the standard counts, the roughly one hundred and sixty degree-granting institutions of 1904 had fallen to eighty-five by 1920 and to sixty-six by 1935; more than half of all American medical schools merged or closed in the quarter-century after the report. The schools that closed were overwhelmingly the proprietary ones — the commercial schools without endowment or university affiliation, unable to afford the laboratories, the full-time faculty, and the teaching hospitals the new standard required and the licensing boards, as the next part will show, soon demanded. In the narrow terms of the product, this was improvement, and the study will not pretend otherwise: the worst schools, the genuine diploma-mills, were destroyed, and the average competence of the American physician rose. But the filter did not distinguish, among the schools it closed, between the fraudulent and the merely poor — and the merely poor included nearly every institution through which Americans without wealth had entered medicine.

## Two — The Near-Extinction of Black Medical Education

The heaviest and most lasting weight fell on the medical education of Black Americans, and here the skew is starkest because the report addressed the matter directly and its author stated the reasoning in his own words. Seven medical schools had been founded to train Black physicians in the decades after the Civil War, in a country whose white schools almost entirely excluded Black students and whose profession — the AMA among it — barred them from membership. These schools were, by the report's template, poor: underfunded, without the laboratories and endowments the standard required, disadvantaged exactly as the Black institutions of a segregated and disinvested society were disadvantaged in everything. The report judged them by the single standard and found five of the seven wanting. Only Howard in

Washington and Meharry in Nashville, Flexner wrote, were "worth developing." The other five were, in effect, marked for closure, and within a decade and a half they were gone.

Flexner set out the role he envisioned for the Black physician plainly, and the sentences are quoted exactly because they carry the design and because paraphrase would soften what should not be softened. The Black doctor, in the report's conception, was to be trained for a limited and subordinate function — to serve Black patients and, above all, to protect white ones from the diseases the report presented Black communities as harboring. "A well-taught negro sanitarian," Flexner wrote, "will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous." The Black physician was to be schooled in hygiene rather than surgery, cast as a sanitary buffer for the white population rather than a full practitioner for his own. This was the racial common sense of educated white America in 1910, and Flexner held it as such — not as a special cruelty but as the obvious way of things, which is precisely how a formation's deepest assumptions are held. The consequence was not obvious common sense. It was a bottleneck in the production of Black physicians that held for more than half a century and whose effects are measurable into the present. Later scholarship has estimated that the five closed schools might otherwise have trained on the order of thirty thousand Black physicians across the century that followed; into the present era, Black Americans remain a small fraction of the profession, and a large share of Black physicians trace their training to the two schools that survived.

The closing of the door was then made permanent by the withholding of the resources that might have kept it open. When the leaders of Howard and Meharry, facing the new and expensive requirements, wrote to the Carnegie Foundation for the funds to meet them, the reply defined the structure exactly. The Foundation would not undertake the commitment; as its representative put it, if it began helping medical colleges for Black students, it could not discontinue. The philanthropy that had funded the survey that raised the standard declined to fund the institutions the standard was destroying. The great foundation money that flowed after the report — Rockefeller and Carnegie capital directed, as intended, to the best schools — flowed to the institutions that already resembled the model, which were the wealthy white universities, deepening the very inequality of resources the standard then punished. The skew compounded itself: the standard condemned the poor school, and the money went to the rich one.

## Three — The Narrowing for Women and the Poor

The same filter narrowed other doors in the same way. The proprietary schools and the less prestigious institutions had been, for all their deficiencies, more open to women and to poor men than the elite university schools that survived; the sect schools, the eclectic and homeopathic institutions, had in several cases admitted women when the regulars would not. As the field contracted to a smaller number of expensive, selective, university-based schools, the entry of women into medicine — which had been rising — stalled and in some measures reversed for decades, and the profession became, for two generations, more male than it had

been before the reform. The general mechanism is the one already named and is not confined to any group: raising the cost and the prior-education requirement of medical training, and cutting the number of places, necessarily favored those who arrived with money and schooling already in hand and disfavored everyone who did not. A poor but able young person of 1900 could still, through a cheap school and hard work, become a doctor. The same person a generation later, facing years of costly college preparation followed by an expensive four-year university course for one of a sharply reduced number of seats, very often could not. The avenue had been improved and narrowed in the same act.

## Four — The Foreclosure of the Alternatives

The report also settled, by the standard's mere application, the sixty-year contest among the medical systems — and settled it, decisively, for the party that had commissioned the survey. The alternative systems — homeopathy, eclectic medicine, and the rest — ran their own schools, and those schools were judged by the same scientific-university template and, being outside the orthodox scientific model by definition, condemned by it. Their schools were told to conform to the model or lose the accreditation and the funding that the new order required, and conform meant, in practice, ceasing to be schools of an alternative system and becoming schools of orthodox scientific medicine, or closing. Most closed. The homeopaths and eclectics, who had held a substantial share of American practice, were driven from the field within a generation; osteopathy survived only by progressively converging on orthodox medicine until it became, in time, a branch of it; the rest largely vanished from legitimate practice.

Here the study must hold both readings at their full and opposed strength, because this is the point at which the honest ledger is hardest to keep. On one reading, this was the victory of science over quackery, and much of it genuinely was: the germ theory had by 1910 been established, effective interventions were arriving, and the scientific model that Flexner's template enforced was in fact the medicine of the future, as the alternative systems mostly were not. The reform did not merely serve the regulars' interest; it also happened to back the party that was, on the central scientific question, right. But on the second reading, held with equal firmness, the contest was decided not by the open competition of results but by the capture of the credentialing power by one of the competitors, at a moment when that competitor's ultimate victory was probable but not yet proven, and the decision then foreclosed the alternatives before the evidence had fully closed the question — extinguishing, along with the genuine quackery, whatever the marginal systems had gotten right and the orthodox model had missed. Both readings are true. The reform was science defeating quackery, and it was also an interested party using a captured lever to end a competition on terms that guaranteed its own supremacy. The framework's discipline is to refuse the comfort of either reading alone.

PART V

# The Institution's Logic

# Part V — The Institution's Logic

The architect's hour ends when the settlement passes out of the hands that designed it and into the institutions that administer it — and from that moment the settlement runs on a logic that is no longer anyone's intention, accumulating consequences no one sat down to will. Flexner's own part was brief. He wrote the report, and he went on to a long and distinguished career in philanthropy and the building of institutions, culminating in the founding of the Institute for Advanced Study; he did not spend the following decades administering the transformation of medicine. He did not need to. He had supplied the settlement, and the settlement was handed to a machine that required no further instruction to carry it forward. This is the deepest point the case makes, and the one that most sharply distinguishes the pattern from the conspiracy it is mistaken for: the durable power was not in the man or in any continuing plot, but in the structure the report's judgment was fed into — a structure that then ran for a century on its own logic, enforced not by plotters but by sincere believers doing what their formation told them was right.

## One — The Lever the Architect Named

The mechanism through which the report acquired the force of law was the state licensing board, and it is one of the quiet elegances of the case that the mechanism was named, with complete clarity, by Flexner himself, to the licensing boards' own assembly, in the year the report appeared. Addressing the national confederation of state medical examining and licensing boards in early 1911, Flexner set out how the whole field could be lifted by the boards' one power — the power to decide whose graduates could be examined for a license, and therefore which schools could place their students in practice at all. The examination for licensure, he told them, is "the lever with which the entire field may be lifted; for the power to examine is the power to destroy." The sentence is the hinge of the institution's logic, and it repays holding. The report itself closed no school; it had no legal force and commanded no one. What it supplied was an authoritative rating — a verdict on which schools were adequate — and the licensing boards, by resolving to admit to their examinations only the graduates of schools the profession's council rated acceptable, converted that rating into a matter of life and death for every school in the country. A school the boards would not examine into could not sell its graduates a path to practice, and would empty and close whatever its own merits. The power to examine was, exactly as Flexner said, the power to destroy, and the boards now aimed it by a standard the profession set.

## Two — The Machine That Ran Itself

The structure that resulted was self-executing, and its self-execution is the whole of the institution's logic. The state boards accepted the AMA Council on Medical Education's ratings as the standard for licensure; the great historian of the profession, Paul Starr, records that the Federation of State Medical Boards came to accept the Council's judgments as authoritative,

giving a private professional body's decisions, in his phrase, "the force of law." A school's fate now depended on a rating issued by the organized profession and enforced by the states' licensing power — a closed loop in which the profession set the standard, the standard governed the license, and the license governed whether a school could exist. No conspiracy was needed to run this loop, and none did run it; it ran itself. Each state board, acting sincerely to protect the public from ill-trained doctors, enforced the rating; each school, to survive, conformed to the standard or closed; each rise in the standard tightened the loop another turn. The credentialing system that controls entry to American medicine to this day — the accreditation of medical schools, the licensing examinations, the residency system layered on later — descends directly from this settlement, and has run forward for over a century on the logic the architect's hour set in motion, long after the men of that hour were dust and their particular intentions forgotten.

The institution's logic delivered, across that century, exactly the consequences the structure's shape made inevitable, whether or not anyone intended them. It delivered a genuine and enormous rise in the quality and consistency of American medical training, which became, over time, arguably the best in the world. It delivered, in the same motion and by the same mechanism, a durable restriction on the supply of physicians — the number of medical school places held down, decade after decade, by an accreditation system the profession controlled, with the predictable effect on physicians' incomes and on the cost and availability of care, a restriction whose benefit to the profession requires no plot to explain because the structure produces it automatically. And it delivered a profession narrower in its social composition and, for the long decades until the barriers were consciously attacked, whiter and more male and richer in origin than the open if disorderly field of 1900 had been. The believers who ran the machine — the licensing examiner protecting the public, the accreditor enforcing standards, the professor upholding rigor — did not experience themselves as the agents of a restriction. They experienced themselves as the servants of quality, and they largely were. The restriction was the structure's doing, not theirs, which is why it proved so durable and so hard to indict: there was no cynic at the center holding the whole design in view, only a vast apparatus of sincere people each doing the right thing as their formation defined it, and the consequences emerging from the arrangement rather than from anyone's controlling will.

## Three — The Ledger

Both columns, in ink, because the discipline of the project is to count the genuine goods of the structures it examines and the genuine costs together, and to let neither erase the other.

In the column of gains, the reform's achievements are real and vast, and no honest account diminishes them. American medical education before 1910 was, at its wide weak end, a scandal that harmed patients, and the reform ended the scandal. It closed the diploma-mills, grounded medical training in the sciences that were in fact transforming medicine, made the laboratory and the supervised clinic the sites of a real education, and raised the average competence of the American physician to a level the old field could never have reached. It aligned American medicine with the scientific method at the moment scientific medicine was coming into its

enormous power, and the century of advances that followed was built on the foundation the reform laid. Billions of patient-encounters since have been safer for it. On the central scientific question of 1910, the reformers were right, and their victory served the public and not only themselves.

In the column of costs, held at equal strength: the reform foreclosed the entry of the poor into a profession they had been able to enter, and did so as a structural effect of raising the price of the door. It devastated the medical education of Black Americans, on a reasoning its author stated in the language of the era's racism, and produced a shortage of Black physicians that harmed Black health for a century. It stalled the entry of women for two generations. It settled the contest among medical systems by the capture of the credentialing lever rather than by the open test of results, foreclosing the alternatives before the evidence had fully closed the question and extinguishing whatever they had gotten right along with what they had gotten wrong. And it handed the organized profession a durable control over the supply of physicians — a control the profession had wanted for sixty years and could not obtain by open means — which it obtained, in the end, not by a plot but by supplying a genuine reform to a structure that then delivered the restriction automatically and forever.

The case resolves, as the project's cases tend to, against both of the easy pictures and into the harder one between them. It was not the impartial triumph of science arranging its own victory by the neutral force of evident truth; a captured lever and a foundation hand in glove with a guild are not neutral forces. Nor was it a conspiracy of financiers and physicians plotting the enrichment of the few — the phrase that the older polemical tradition, and its contemporary descendants, reach for when they meet this history and find a Rockefeller and a Carnegie standing near a profession's rise. It was an architect's hour and an institution's logic: a real problem, solved by a few actors in adjacent positions who converged in the open and skewed the solution, in plain sight, toward the model they revered and the position they held; a settlement then handed to a machine of licensing boards and accreditors that ran it forward for a century on its own logic, needing no further intention; and an army of sincere believers who enforced the result as quality because quality, to them, was what it sincerely was. The most durable power in the story is not a person and not a plot. It is the credentialing structure itself — built in a bounded hour by men formed to see one model as the only model, and running still, on the belief of everyone who serves it, as the settled and invisible way of things. Held, like everything in this project, as tested, not revealed.

## A Note on Sources

This is a work of synthesis, and the figures and quoted words have been drawn from the scholarly and documentary record.

The landscape of nineteenth-century American medicine — the open field after the Jacksonian repeal of licensing, the competing sects, the proprietary school as a commercial form, and the profession's long effort to close the field — follows Paul Starr's *The Social Transformation of American Medicine* and the standard histories of the AMA and the Council

on Medical Education. The founding of the Council in 1904, its two standards, its survey and ratings of 1906–1907, and its decision to route publication through the Carnegie Foundation rather than publish under its own name follow the AMA's own institutional history of the Council and the accounts assembled by later historians; Pritchett's admission that the Foundation worked "hand in glove" with the Council appears in his correspondence with Arthur Dean Bevan and is reproduced in the historical literature on the report.

Flexner's biography — the Louisville household, the panic of 1873, the mutual-financing of the siblings' educations, the two years at Johns Hopkins, Mr. Flexner's School, the Harvard and German study, and *The American College* of 1908 — follows the standard biographical record, including Thomas Neville Bonner's *Iconoclast: Abraham Flexner and a Life in Learning*, the Institute for Advanced Study's biographical account, and Flexner's own autobiography, the source of his self-description as "an industrious and perhaps intelligent thief." The commissioning by Pritchett and the conduct of the 1909–1910 survey with Nathan Colwell of the AMA Council follow the same record.

The report *Medical Education in the United States and Canada* (Carnegie Foundation Bulletin No. 4, 1910) is quoted from its text for the treatment of Black medical education, including "worth developing" and the sentence contrasting the "negro sanitarian" with the "essentially untrained negro wearing an M.D. degree." The closure figures — roughly 160 schools in 1904 falling to 85 by 1920 and 66 by 1935 — follow the standard counts reproduced in the *Flexner Report* literature. The near-extinction of Black medical education, the survival of only Howard and Meharry, the Carnegie reply that it could not begin helping Black medical colleges without being unable to discontinue, and the projected estimate of tens of thousands of Black physicians not trained across the following century follow the scholarship on the report's racial legacy, including the JAMA and AMA Journal of Ethics treatments and the projection studies of the closed historically Black schools.

Flexner's statement to the National Confederation of State Medical Examining and Licensing Boards in 1911 — that "the examination for licensure is the lever with which the entire field may be lifted; for the power to examine is the power to destroy" — is quoted from the published proceedings of that meeting. The mechanism by which the state boards gave the Council's ratings "the force of law," through the Federation of State Medical Boards, follows Paul Starr. The counter-reading that the reform was the genuine triumph of scientific medicine, and the account of the alternative systems driven from the field, follow the standard histories and the treatments of the report's centenary.

Contested matters are flagged as such, and no verdict rests on the strongest form of any disputed claim. Where the study errs, it should err visibly, in a form the cited scholarship can correct.

Part of the collection *Patterns of Power*. Tested, not revealed.